

EMPLOYEE DISABILITY CHECKLIST

Please complete the enclosed forms in full, and in ink. Ensure all forms are signed and dated where applicable.

- Direction and Authorization Form
 TOTAL TOTAL
- o Employee Statement
- Attending Physician's Statement (take full package to your attending physician who will complete the appropriate form)
- Void cheque

Mail, fax or email completed forms to:

Mail:

JG Benefits Inc.

1051 King Edward Street Winnipeg, MB R3H 0R4

Fax:

1-833-702-4687

Email:

disability@cinup.ca

Should you have any questions, please contact the CINUP Disability team at 1-800-665-1234

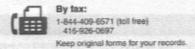
DIRECTION	AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION
FROM	Employee's (Claimant Name)
то	Desjardins Financial
RE	RELEASE OF CONFIDENTIAL/PERSONAL INFORMATION TO JG Benefits Inc./CINUP (hereinafter "Policyholder")
INDIVIDUA	L POLICY NUMBER : Select Policy Number
Inc./CINUP) evaluation by vocational, re documentatio Financial) to	et and authorize the company to discuss with the Policyholder (JG Benefits any and all information or documentation concerning my claim and its the company, including but not limited to, any medical, financial, habilitation, or any other confidential/personal information or in concerning my claim. I also authorize the Company (Desjardins send to the policyholder, copies of correspondence the Company receives terning my claim as well as any medical information received from external
Duration and	d Revocation
disclo This a servic I am f	that of a requirement of the Policy/Policies that I authorize the company to se information to the Policyholder authorization will remain valid for as long as I am claiming benefits or se from the Company: and, free to revoke this authorization at any time by sending written notice to the sany of such revocation.
I have read an compulsion b	nd understand the above. I am signing this voluntarily, and not under by anyone.
West	
Signature of	Claimant Date



Submit online:

desjerdinslifeinsurance.com/send Complets and save the form on your computer first. Keep original forms for your records.





Contact us: 1-800-263-1810 (toll free) or 416-926-2990



GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM

EMPLOYEE STATEMENT

The payment of your disability claim will be made by direct deposit only. Please include a specimen cheque marked «VOID».

ast name and first name of employee		Sex	Date of birth	
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Your social insurance number is necessary only if your disability claim	ms are avable Please contact v	our employer to obtain	this information.	
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Spoken language: 🏋 English 🔲 French Written la	anguage: English Fren	nch		
Is disability due to an accident? If "Yes", date of accident:	Time	Type of accident	and subsent toni	e and arrighted
☐ Yes Id No I	DO DAM	☐ Work-related	☐ Motor vehicle	Other
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PLEASE COMPLETE THE BACK OF THE FORM.

06329E01 (2018-11)

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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D - PERSONAL INFORMATION Designations Insurance handles the may benefit from group insurance to so in the course of their work. Insurance may also communicate have information corrected if your collowing address: Privacy Officer, to offer its clients an insurance programment of the programment of	personal inform services offer Desjardins Insu with plan mem demonstrate If Desjardins Insu	mation it has on you is red by the Company. urance may compile or the bers to provide them that it is inaccurate, in urance, 200, rue des the termination of the	This informanonymize with optim accomplete, Commander group in	nation is d perso nal heal ambigu deurs, L surance	s consulte nal inform th manage lous or no évis, Quét s. If you do	d solely by lation for sta ement. You at useful. To bec, G6V 6i o not wish to	Desjard atistical have the do so, R2. Desj receive	tins Ins and info e right to you mu ardins	urance en ormational o consult est send a Insurance	nployee I purpos your file written may us	s who no ses. Desj . You ma request se the clie	eed to ardins y also to the ent list
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Signature of employee:

VERY IMPORTANT

Please have the Initial attending physician's statement completed and submit the completed forms online, or by mail or fax to: Desjardins Insurance – Disability Claims.

employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.

Provided that I have filled out the appropriate boxes, I authorize Desjardins Insurance to email me at the address provided in section A of this form and I give

I authorize Desjardins Insurance to use or communicate my social insurance number for tax purposes. A photocopy of this authorization is as valid as the original.

Date:

Desjardins Insurance permission to leave voicemail about my disability claim at the phone number provided on this form.

October 3, 2022

To: Whom it may concern

Re: Void Cheque

Please accept this copy of a void cheque as confirmation of MEGAN WOOD's bank account information for the purposes of pre-authorized debit or credit.

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MEGAN WOOD

934 MOUNTDALE AVENUE THUNDER BAY, ON P7E2Z9

VOID

2022 10 03 Date: YYYY MM DD \$

Transit Number. Institution Number. Account Number.

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5060520

Royal Bank of Canada Website, © 1995-2022



IRRECRIANT NOTE TO CLAIMANT

Attending Physician Statement

(Please take full package to your physician)

is exportant that your physician fully complete the form that best corresponds to your medical and cissure your claim is processed promptly.

There is abolity feature the complete form to Designatins (marcial security life Assurance Company, eminater Designatins Ingerance, as soon as possible.

Coloret personale distrement and send

PO Box 1203 STN A Toronto ON INSW 166



Submit online:

desiardinslifeinsurance.com/send Complete and save the form on your computer first. Keep original forms for your records.



PO Box 1203 STN A Toronto ON M5W 1G6 Send original forms and keep copies for your records.



INITIAL ATTENDING PHYSICIAN'S STATEMENT

By fax: 1-844-409-6571 (toll free) 416-926-0697

Keep original forms for your records.

GENERAL FORM

Desjardins

Insurance

Life · Health · Retiren

A PLEASE PRINT.

PART 1 to be completed by patient.

Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)

PART 2 to be completed by physician.

Policy or group or contract no. 641028

Certificate or identification no.

Date of birth

PART 2 - Attending physician's statement

decision to have your full clinical notes from the date of disability and any consultation re

	Diagnosis (including complications) - If psychiatric, give DSM-IV code.	
.1	Primary:	5.3
.2	Secondary:	3-5
3	Subjective symptoms (including severity, frequency, duration):	8.1
	Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings):	-
.4		-
.5	Degree of severity of all symptoms: Mild Moderate Severe With psychotic elements	
2.	History	
.1	Date symptoms first appeared or accident happened:	
2.2	Date patient's condition first prevented them from working: Has this patient ever had same or similar condition? Yes No Unknown	
2.3	Has this patient ever had same or similar condition?	5.0
	if yes, please specify diagnosis and dates of deadliests.	3.6
2.4	Is condition due to injury or sickness arising out of patient's employments? Yes No Unknown Have Worker's Compensation/CSST forms been completed? Yes No Unknown	
2.6	If patient is pregnant, give E.D.C.:	
2.7	Names and specialties of other treating physicians:	
2.8	Current height: Current weight: Weight loss/gain to date:	- 1
3.	Treatment dates	
3.1	Date of first visit for current condition: 3.5 Date of discharge: 444 Date of discharge:	
3.2	Date of latest visit: 3.6 Date of out-patient treatment: 7777 MMS DD	
3.3	Frequency of visits: Weekly Monthly 3.7 Name of hospital:	.03
	Other (specify):	
3.4	Date of in-patient admission: YPFO NOBO DO	
4.	Nature of treatment	
4.1	Medications (dose, frequency, date prescribed):	-
4.2	Surgeries (including dates):	6.1
	Other lindusting fraguency):	
4.3	Other (including frequency):	



Submit online:

desiardinsifeinsurance.com/send

Complete and save the form on your computer first.

Keep original forms for your records.



By mail:
PO Box 1203 STN A
Toronto ON MSW 166
Send original forms and keep copies for your records.



By fax: 1-844-409-6571 (toll free) 416-926-0697 Keep original forms for your records.



INITIAL ATTENDING PHYSICIAN'S STATEMENT MUSCULO-SKELETAL FORM

0	PLEASE PRINT.	
0	PART 2 to be completed by physic	cian.

PART 1 to be completed by patient.

Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)

Policy or group or contract no. 641028 Certificate or identification no.

Date of birth

case manife and man man by the service

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

	Diagnosis	
1.1	Primary:	-2 Physiotherapy Dyon, Inquering datests
.2	Secondary:	1080 NSO (40802 E.
1.3	Date symptoms first appeared:	
1.4	Date patient's condition first prevented them from working:	
1.5	Date of first visit for treatment or consultation:	
1.6	Has patient ever had the same or similar condition? Yes No Unknown	If yes, state when and describe:
1.7	Is condition a result of an injury due to an accident?	If yes, please describe:
1.8	Current height: Current weight:	Weight loss/gain to date:
	Is condition due to injury or sickness arising out of patient's employment?	Unknown
	If yes, have Worker's Compensation/CNESST forms been completed?	
1.10	Date of latest visit:	
	Frequency of visits: Weekly Monthly Other (specify):	More and weedpass C
	Date of hospital inpatient admission:	
	Date of discharge:	
	Date of hospital outpatient admission:	
1.15	Name of hospital:	I Traggers for except of
1.16	Other treating physicians:	VIDERALIZATION PART PROTECTION OF THE PROTECTION OF THE CONTRACT OF THE PROTECTION OF THE PROT
1.17	Pending referrals to specialists:	SITUATION OF THE CHILD AND THE STORY OF THE
2.	Studies	
	Please outline all objective studies performed/scheduled (X-rays, laboratory data, CT scans, etc.)	and attach copies of each report.
	Date Procedure	Results
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	YYYY MM DD	220,019
	PYYY MM DD PROGRAMMED SANGON TON'T	Policing folial parameters (2) Produce (cris 4)
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8.	Assessment and treatment are complicated by: (please	selec	t and e	explain in the space	e provided below	Principle of		
8.1	Significant emotional or behavioural disorder such as depression, a	nxiety,	etc.		devices to	ations.		
8.2	Exaggeration, inconsistent findings, subjective complaints out of pr	roportio	n to obje	ective findings, bizarre o	or contradictory observ	vations.		
	☐ Work related issues (please describe if known):	4171	111			anily sale	J Dec	3
	☐ Substance abuse:					100	Pulsa!	-
	Other (please describe):					1000110410	100 100	_
9.	Rehabilitation							
9.1	Is patient a suitable candidate for medical rehabilitation services?	Yes	□No					
9.2		Yes	□No					
3.2	If yes to either of the above, please specify:		-					_
	is yes to entire or the second							
10	Comments							
10.	Is there any other information you wish to add that will give us a bet	ter und	erstandir	ng of your patient's con-	dition or treatment re	quirements?		
	is there any other manners and government and all carest of a	divisi 10	90000	4 \$505P4 DHONEST SHOT				-
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	Identification of physician Last name and first name (PLEASE PRINT)			11.2 Specialty		License no.		
11.	1 Last name and first name (PLEAGE PRINT)						- A 65 C	5.1
11.	3 Address - No., street, suite	City			Province	Postal coo	le .	
							77342	
11.	4 Telephone no.: () -			Fax no.: (,	returning the pur		-
Sie	mature of physician:				Date:		Assist.	-5
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-	erapy method:								
Th	erapy goal:								
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5.	Restrictions a	nd limitations					
			o-Vascular Society (CCS 2 (mild impairment)	Level 3 (modera	ite impairment) Leve	el 4 (severe impairmen	0
	Functional capaci		,	_			
		1-10 (0.5 - 4.5	kg) Frequency:				
	STATEME	11-20 (5.0 - 9.1	kg) Duration:	ITA JAITIVI			Liberianding
		21-50 (9.5 - 22.3					
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	Standing:	hours	\$25500000 vi 618	record your properties	r he modesky earn sóil agreeth o		AND The burgerood by the
	Walking:		Frequency:				
	_	evoked: Yes				Implime to	ART 1 - Jelevichenstron e
				Top Properties of	contra mini		
5.3	What specific res	strictions or limitation	ons prevent the patient	t from performing th	ne duties of his/her occupati	ion?	7 FW1 PRODUCTION AND AND SHIPLE TO
5.4	How does this af	fect the patient's ab	bility to perform activit				uriq şelbestifi. E Tile
6.	Patura to wo	rk nlans		piperina hal kumaasa			
6.1	Prognosis for me	dical recovery:	on, operativa and	ionalesees lin to	- Please attach a copy	productions y	n gribe hell stangald
6.2	Expected date pa	atient will return to	their own occupation:	YYYY ME	00		
6.3	If unknown, plea	se indicate the next	follow up date:	VOV	- V		
6.4	If your patient is gradual return to		their own occupation,	please specify when	and under what circumstan	nces they could return	to modified duties or
7.	Assessment a	and treatment a	are complicated by	y: please select a	nd explain in the space	ce provided below	
7.1 7.2	Significant em	otional or behaviou inconsistent finding	ral disorder such as de s, subjective complain	pression, anxiety, etc ts out of proportion t	:. to objective findings, bizarrë	or contradictory obse	rvations
7.3	☐ Work-related	issues (please descr	ibe if known):	Distraye	ALC DESCRIPTION		and the state of t
7.4	Substance abo						
7.5	Other (please	describe):					
8.	Progress						
8.1 8.2	Has patient: Current status:	☐ Recovered ☐ Ambulatory	☐ Improved ☐ House confined	☐ Not improved ☐ Bed confined	☐ Retrogressed ☐ Hospital confined		
9.	Rehabilitatio	n			The second second		
			edical rehabilitation se	ervices? (i.e. cardioou	imonary program, speech ti	herapy, etc):	Yes No
312			edital rendomiation se				the second second
9.2			ocation rehabilitation?	□Yes □No	If yes, please specify:		
10.	Comments						
	Is there any other	er information you v	wish to add that will give	ve us a better unders	tanding of your patient's cor	ndition or treatment re	quirements?
				and the state of the state of	A MARINE WELL THE STATE OF	Transaction of the Control	
							Topic by let
11.	Identification	n of physician					
11.1	Last name and fi	irst name (PLEASE P	RINT)		11.2 Specialty		License no.
11.3	Address - No., st	treet, suite		City	Province	Postal code	Act of something agents.
11.4	Telephone no.: (()		Fax no.:	()	- Table of decisions
	ature of physician					Date:	

5.1		to date: \[\D\/A \] P	Partial Complete			
	Describe the therapies	io dote.				
5.2	Describe all co-morbid	tonditions:				
5.3	Describe any post there	py sequelae:				
5.4		ent's prognosis for improveme				
5.5	Is the condition due to	injury or sickness arising out of	f the patient's employment?	Yes No		
6.	Patient's current p	hysical abilities				
5.1	Please indicate your pa	tient's current physical abilities	s:			
	Sedentary duties:	Mainly sitting, occasional wa	alking and standing, and pos	sible lifting of 5 kg or les	5.	
	☐ Light duties:	Frequent handling of loads of degree of pushing and pulling	of up to 5 kg, sometimes up ing of arm and/or leg controls	to 11 kg; may require fre s.	equent walking or stan	ding, or sitting with a
	Medium duties:	Frequent handling of loads of Frequent lifting, carrying, pu				
	☐ Heavy duties:	Frequent handling of loads u	up to 23 kg, sometimes up to	o 45 kg.		
6.2	In your opinion, what i	s the earliest date your patient	will be able to return to wo	rk?	5638 00	
			min be built to return to mo			
5.3	If the previous job cou	d be modified, when could reh		nmence?	MON DO	
	If the previous job cou	d be modified, when could reh		nmence?	May DO	
7.	Comments		nabilitation employment corr	invence:		any available
6.3 7. 7.1	Comments	nes of other physicians who ha	nabilitation employment corr	invence:		any available
7.	Comments Please provide the nar	nes of other physicians who ha	nabilitation employment corr	invence:		any available
7.	Comments Please provide the nar	nes of other physicians who ha	nabilitation employment corr	invence:		any available
7.1	Comments Please provide the nar consultation reports:	nes of other physicians who ha	nabilitation employment con	assessing the medical pr	oblems and copies of	any available
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7.1	Comments Please provide the nar consultation reports: We would appreciate a	nes of other physicians who ha any additional comments that v	nabilitation employment con	assessing the medical pr	oblems and copies of	License no.
7. 7.1 7.2	Comments Please provide the narconsultation reports: We would appreciate a	nes of other physicians who has any additional comments that when the second sec	nabilitation employment con	assessing the medical properties of the medi	oblems and copies of	License no.
7. 7.1 7.2 8. 8.1	Comments Please provide the narconsultation reports: We would appreciate and instruction of pleast name and first name	nes of other physicians who has any additional comments that when the second sec	we been/will be involved in a	assessing the medical properties of the medi	oblems and copies of	License no.



IMPORTANT NOTE TO CLAIMANT

In order to avoid any delays in the assessment of your claim, please have your physician complete the appropriate Initial Attending Physician's Statement form:

- General

Form no. 12018E01

- Musculo-skeletal

Form no. 12019E01

- Psychiatric/psychological

Form no. 12020E01

- Cardiac

Form no. 12021E01

- Cancer Form no. 12022E01

We have sent you all five of the above-mentioned Initial Attending Physician's Statement forms, each of which is specific to a particular illness. Please give all five forms to your physician so they can fill out the appropriate one.

It is important that your physician fully complete the form that best corresponds to your medical condition to ensure your claim is processed promptly.

Short Term Disability: Return the complete form to Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, as soon as possible.

Long Term Disability: Return the complete form to Desjardins Insurance no later than six weeks prior to the start of your long-term disability period.

Online: desiardinslifeinsurance.com/send

Desiardins Insurance PO Box 1203 STN A Toronto ON M5W 1G6

Fax: 416-926-0697 or 1-844-409-6571